

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026593

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

1965

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4031

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		c. CITY OR TOWN Ferguson	
Length of stay in 1b 6 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopath Hosp.		d. STREET ADDRESS 618 Tesmore Dr.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chester Middle R. Last Carlson		4. DATE OF DEATH Month June Day 17 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-20-84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R. R. Ex. Agent		10b. KIND OF BUSINESS OR INDUSTRY Express	
11. BIRTHPLACE (City and state or country) LaRose, Illinois		12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME Emil Carlson		13b. MOTHER'S MAIDEN NAME Christine Olson	
14. NAME OF HUSBAND OR WIFE Gertrude A. Carlson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Gertrude A. Carlson, Ferguson, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic Encephalomalacia Cerebrovascularatherosclerosis DUE TO (b) Cerebrovascularatherosclerosis DUE TO (c) Aortic atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Aortic aneurysm PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour --- a.m. --- p.m. Month, Day, Year ---	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 6-11-63 to 6-17-63 and last saw her alive on 6-17-63 Death occurred at 12:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) David R. Gardner M.D.		22b. ADDRESS 7520 Natural	
22c. DATE SIGNED 6-18-63		22d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-20-63	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR ADDRESS White-Mullen Mortuary, Ferguson, Mo.		25. DATE RECD. BY LOCAL REG. 6-18-63	
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Reinhold F. Lohrmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.